DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 9 4 — 3 6

2. STATE: New York

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 1994

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Part 447

7. FEDERAL BUDGET IMPACT:
a. FFY 1993-1994 $ 14.4 m
b. FFY 1994-1995 $ 14.65m

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A Part 1 Pages 112(f)(1),131(e), 131(f),131(g),149,149(a),185(a),236,237,238

*** SEE REMARKS

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A Part 1 Pages 112(f)(1), 131(e),131(f),131(g),149,149(a),185(a), 236,237,238

10. SUBJECT OF AMENDMENT:
Inpatient Hospital **Services**

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL: [signature]

13. TYPED NAME: Michael J. Dowling

14. TITLE: Commissioner

15. DATE SUBMITTED: September 30, 1994

16. RETURN TO:
New York State Department of Social Services
40 North Pearl Street
Albany, New York 12243

17. [illegible]

19. [illegible] 07/01/94

21. TYPED NAME: Sue Kelly

22. TITLE: Associate Regional Administrator
Division of Medicaid [illegible]

23. REMARKS: [illegible] Attachment 4.19-A Part 1 Page 185(a) has been withdrawn. [illegible] 131(g), and 149 are the only approved pages from the originally [illegible] The following pages have been revised and approved: [illegible]

FORM HCFA-179 (07-92)

Instructions on Back

86-1.52(9/94)
Attachment

4.19-A

Part I

(DRGs) 475,483,540, 701-716 and 798-801.

(b) $63 million shall be allocated to general hospitals for labor adjustments. Such amount shall be allocated as follows:

(1) An amount equal to $55 million shall be allocated for labor cost increases incurred prior to June 30, 1993. Amounts allocated to each general hospital shall be based on the general hospital's share of the statewide total of inpatient and outpatient reimbursable operating costs based on 1990 data excluding costs related to inpatient services provided to beneficiaries of title XVIII of the Federal Social Security Act (Medicare) and excluding direct medical education costs, as determined pursuant to section 86-1.54 (g) (3);

(2) An amount equal to $8 million shall be allocated for labor adjustments to general hospitals located in the counties of Ulster, Sullivan, Orange, Dutchess, Putnam, Rockland, Columbia, Delaware and Westchester, to account for prior disproportionate increases in unreimbursed labor costs. Each general hospital determined pursuant to this subclause shall receive a portion of the $8 million equal to the general hospital's portion of the total inpatient and outpatient reimbursable operating costs based on 1990 data for all hospitals located in the counties identified pursuant to this subclause, excluding costs related to services provided to beneficiaries of title XVIII of the Federal Social Security Act (Medicare) and excluding direct medical education costs, as determined pursuant to section 86-1.54(g)(3).

(c) $55 million shall be allocated for increased activities related to regulatory compliance ~~for~~, universal precautions and infection control related to AIDS, tuberculosis, and other infectious diseases including the training of employees with regard to infection control, and for infectious and other waste disposal costs. A fixed amount per bed shall be allocated to the costs of each general hospital based on the total number of inpatient beds for which each hospital is certified as of August 24, 1993.

(d) An amount equal to $3 million shall be allocated to the costs of each general hospital in the following manner and which meet the following criteria:

(1) $250 per bed shall be allocated to the costs of each general hospital having less than 201 certified acute care beds as of August 24, 1993 and classified as a rural hospital for purposed of determining payment for inpatient services provided to beneficiaries of title XVIII of the Federal Social Security Act (Medicare) since the hospital is located in a rural area as defined by Federal law (see 42 U.S.C. section 1395 ww(d) (2) (D) or defined as a rural hospital under section 700.2 (a) (21) of

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Resident Matching Program during the period January 1, 1988 through December 31, 1992 shall not be assigned a physician specialty weighting factor of 1.5 for rate years commencing on or after January 1, 1994 unless the program complies with the provisions of [~~subclause~~] item (ii) of this [~~clause~~] subclause.

(ii) The physician specialty programs of internal medicine, combined internal medicine/pediatrics, and pediatrics which demonstrate through an application to the New York State Department of Health, that they have a curriculum in physician-patient communication, which includes medical interviewing, psychological aspects of care, and patient counseling and education; continuity of care experience which comprises 10 percent of training time during each year of the program and 20 percent of the total residency training period, is scheduled in at least nine months of each year of training, and occurs at a site which encourages continuity of care by attracting patients for longitudinal and comprehensive care, by using an appointment system that accommodates personal appointments, walk in patients and referrals and allow ample time to include physical examinations, treatment and patient teaching during appointments, providing after hours coverage by providing prompt telephone access to a clinical staff member on a 24 hour basis who can respond to health care problems, assigning residents or a team of residents to provide care for a specific panel of patients, operating at least 40 hours per week, including at least 8 hours during evenings or weekends, providing a tracking system to document care given to patients when the patients are sent to an emergency service, hospital or other provider of health care service, assisting services, and monitoring reports and results of off-site services and integrating results into patient records; and which reflect a program emphasis on primary care in its residency recruitment materials, shall be assigned a physician specialty weighting factor of 1.5 for rate periods commencing July 1, 1994 and subsequent annual rate periods commencing July 1, 1995.

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New York
131(f)

(2) The physician specialty weighting factor for the physician specialties of family practice-geriatric medicine, internal medicine-geriatric medicine, combined internal medicine/pediatric programs, **general practice residency in dentistry, advanced general denistry programs** and categorical three-year pediatrics programs other than those identified in subclause (1) of this clause, shall be determined such that the sum in total for all general hospitals of the results of the application of the weighting factors to the indirect medical education expenses for each general hospital shall equal, approximately, the sum in total for all general hospitals of the indirect medical education expenses for each general hospital as if the provisions of subparagraph (i) of this paragraph were applied. The 1990 data and statistics for the Hospital for Joint Diseases Orthopedic Institute, Inc., Hospital for Special Surgery, Manhattan Eye, Ear and Throat Hospital and the New York Eye and Ear Infirmary shall be excluded from the above calculation.

(3) The physician specialties of emergency medicine and preventive medicine, including public health, general preventive medicine and occupational health, shall be assigned a physician specialty weighting factor of 1.1. The physician specialty programs of obstetrics and gynecology which demonstrate through an application to the New York State Department of Health that they have a curriculum in physician-patient communication, which includes medical interviewing, psychological aspects of care, and patient counseling and education; continuity of care experience which comprises 10 percent of training time during each year of the program and 20 percent of the total residency training period, is scheduled in at least nine months of each year of training, and occurs at a site which encourages continuity of care by attracting patients for longitudinal and comprehensive care, by using an appointment system that accommodates personal appointments, walk in patients

OL with approval

and referrals and allows ample time to include physical examinations, treatments and patient teaching during an appointment, providing after hours coverage by providing prompt telephone access to a clinical staff member on a 24 hour basis who can respond to health care problems, providing care for pregnant and non-pregnant women, assigning residents or team of residents to provide care for a specific panel of patients, operating at least 40 hours per week, including at least 8 hours during evenings or weekends, and providing a tracking system to document care given to the patient when the patient is sent to an emergency service, hospital or other provider of health care service, assisting the patient with arrangements or making arrangements for off-site services, and monitoring reports and results of off-site services and integrating results into patient records, and which train residents to include health maintenance and disease prevention in their patient care, including instruction in breast examinations, mammograms, blood pressure measurements, skin tests for tuberculosis, immunizations, HIV counseling, smoking cessation and drug abuse counseling; and which reflect a program emphasis on primary care in its residency recruitment materials, shall be assigned a physician specialty weighting factor of 1.1 for at least two and no more that three subsequent rate periods commencing July 1.

(4) The physician specialties of categorical three-year internal medicine programs other than those identified in subclause (1) of this clause and osteopathic internship shall be assigned a physician specialty weighting factor 1.0.

(5) The physician specialties and subspecialties not defined in subclause (1),(2),(3) or (4) of this clause shall be assigned a physician specialty weighting factor of 0.9.

(c) The indirect teaching adjustment percentage for the rate period shall be weighted based on projected medical education statistics for the general hospital as of July 1 for the period and subsequently

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86-1.60 Billing provisions and limitations on changes in case mix. (a) Billing provisions. For purposes of initial billing of governmental payors only, hospitals may bill upon admission of the patient, subject to the provisions of this section, provided, however, that the hospital submits a final bill for the patient whose DRG assignment and final payment will be determined in accordance with the provisions of this Subpart. All initial payments made based upon admission of the patient will be reconciled on discharge. Furthermore, adjustments shall be made on a quarterly basis, including any adjustments to rates of payment made pursuant to the provisions of subdivision (b) of this section.

(1) For purposes of billing upon admission for the first quarter of 1988, an initial admission payment shall be determined as specified in paragraphs (a)(1), (2), (4) of section 86-1.52 of this Subpart, except that the operating cost component specified in section 86-1.52 (a)(1) shall be determined based upon a hospital specific case mix index (CMI) developed for governmental payors using the data used to calculate initial 1988 rates of payment.

(2) For purposes of billing upon admission for each quarter subsequent to the first quarter of 1988, an adjustment to the hospital's CMI shall be made based upon the allowable aggregate statewide increase in the hospital's CMI, as determined pursuant to subdivision (b) of this section, for the previous quarter.

(b) Limitations on changes in case mix.

(1) For **the** rate [years] **period** commencing January 1, 1994 **and ending June 30, 1994,** the maximum allowable increase in the non-Medicare statewide average reported case mix in an historical rate year shall not exceed, on a cumulative basis, two percent from the 1992 non-Medicare statewide average reported case mix for 1994 ~~[and an additional one percent per year thereafter from the 1992 non-Medicare statewide average reported case mix]~~, excluding case mix changes due to acquired immune deficiency syndrome, tuberculosis, epidemics or other catastrophes.

New York
149(a)

86-1.60(9/94)
Attachment 4.19-A
Part I

For the rate period July 1, 1994 through December 31, 1994, the maximum allowable increase in the non-Medicare statewide average reported case mix in an historical rate year shall not exceed, on a cumulative basis when taking into consideration the rate of growth between the 1992 and 1987 rate years, six and two tenths percent from the adjusted 1992 non-Medicare statewide average reported case mix for 1994. For rate years commencing January 1, 1995, the maximum allowable increase in the non-Medicare statewide average reported case mix shall not exceed, on a cumulative basis, three percent from the 1992 non-Medicare statewide average case mix for 1995 and an additional one percent per year thereafter from the 1992 non-Medicare statewide average reported case mix. The maximum allowable increase shall be applied to adjust rates of payment [~~for the periods commencing January 1, 1990 and thereafter,~~] using the following methodology:

(i) the case mix adjustment percentage determined pursuant to this subparagraph plus the case mix adjustment percentage determined for the 1992 rate year, and further plus an adjustment to reflect the difference in measurement of the percentage change from 1992 rather than 1987 to maintain the effective maximum rate of allowable increase in non-Medicare statewide average case mix at two percent from 1987 for 1988 and one percent per year thereafter except for the period July 1, 1994 through December 31, 1994; shall be multiplied by the hospital specific average reimbursable operating cost per discharge, the group average reimbursable operating cost per discharge and the basic malpractice insurance cost per discharge and the result subtracted from such amount before application of the service intensity weight for the applicable rate year determined pursuant to section 86-1.63 of this Subpart.

(a) A reported non-Medicare statewide increase in case mix index shall be determined by dividing the statewide rate year case mix index determined pursuant to paragraph (4) of subdivision (b) of section 86-1.75 by the statewide base year case mix index determined pursuant to paragraph (2) of subdivision (b) of section 86-1.75 and subtracting one from the result.

(b) An estimated real non-Medicare statewide increase in case mix index shall be determined by dividing the estimated real rate year case mix index determined pursuant to paragraph (6) of subdivision (b) of section 86-1.75 by the estimated real statewide base year case mix index determined pursuant to paragraph (6) of subdivision (b) of section 86-1.75 and subtracting one from the result.

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86-1.86 (9/94)
Attachment 4.19A
Part I

86-1.86 Rural health network rate enhancements. The rate enhancements provided in subdivisions (a) and (b) of this section shall be included in the operating portion of the reimbursement rate of general hospitals participating within a central services facility rural health network or a rural health network.

(a) Central Services Facility Rural Health Networks. For rate periods beginning July 1, 1994, a rate enhancement of $1.5 million shall be added to the inpatient hospital payment rates of those general hospitals participating within a central services facility rural health network as defined in subdivision (e) of this section. An additional enhancement of $1.5 milliontrended to the 1995 rate period by the applicable trend factor calculated pursuant to section 86-1.58 of this Subpart shall be added to the 1995 inpatient hospital payment rates of those same participatinghospitals. This enhancement is to encourage hospitals toparticipate in this type of network. The enhancement will be allocated to each eligible hospital based on the methodology described in paragraph (c) of this section using budgeted costs pertaining to participation in the network.

(b) Rural Health Networks. A rate enhancement of $3.0 million will be added to the 1995 inpatient hospital payment rates of those general hospitals participating within a rural health network as defined in subdivision (f) of this section. The enhancement shall be allocated to each eligible hospital based on the methodology described in paragraph (c) of the section using budgeted costs pertaining to participation in the network.

TN 94-36 Approval Date JUN 06 2001

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(c) Funds shall be allocated based upon budgeted costs of general hospitals participating within a central services facility rural health network or a rural health network which are determined by the Commissioner to be reasonable using generally accepted accounting principles. Costs which qualify for rate enhancements made pursuant to subdivision (a) and (b) of this section must be related to inpatient services and shall include, but not be limited to, activities that support the functioning of primary care hospitals; activities that improve the accessibility of a full continuum of care for residents in the network's service area; activities that support the effective and efficient delivery of comprehensive primary, acute inpatient and emergency medical care; activities that improve clinical information sharing, communication, and cooperation between general hospitals and local providers and between general hospital network members and regional providers; activities that promote cost efficiencies in service delivery through system-wide integration of organizations and/or services; activities that support the development of new services designed to meet newly identified health and health related needs of the network service area including linkages of public health services provided by county health departments; and activities that support increased integration or coordination of existing organizations and/or services to address identified and unmet health and health related needs of the service area or specific underserved populations within the service area.

(d) General hospitals (including state designated primary care hospitals as defined in subdivision (g) of this section and federally designated Rural Primary Care Hospitals as defined in 42 CFR Part 485) shall apply to the Department of Health for rate enhancements available pursuant to subdivisions (a) and (b) of this section using a format provided by the Department no later than November 1, 1994. Such application shall identify the costs associated with participating in a central services facility rural health network or a rural health network and describe the purposes and uses of the rate enhancements being sought.

(e) A Central Services Facility Rural Health Network (CSFRHN) is defined as an incorporated rural health network that is authorized to plan and coordinate services, secure and disburse funds, and enter into agreements with other organizations. CSFRHNs are governed by a board of directors made up of participating providers and consumers from the communities served by the network. Member organizations retain their separate corporate entities.

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86-1.86(9/94)
Attachment 4.19A
Part I

(f) A rural health network is defined as a locally directed organization involving contracts or joint or operative agreements among health care providers serving an underserved rural area. Networks may plan, coordinate, provide or arrange for the provision of health care services to residents of the area and/or provide related administrative services among such health care providers. Health care services may include: primary and preventive care, emergency care, acute care, medical/surgical care, laboratory and radiological services, tertiary care, swing bed care, therapeutic care services, home health and skilled nursing care, hospice, respite care, and other necessary human services. Administrative services may include emergency medical services training, credentialing, payroll, purchasing and billing services, recruitment of qualified personnel and support of network communication, medical transportation, quality assurance, risk management, peer review, electronic data sharing and managed care systems. Rural health networks may include primary care hospitals and/or up-graded diagnostic and treatment centers.

(g) A designated primary care hospital is defined as an acute care facility that provides limited inpatient services necessary to support locally based primary care services. Services are provided in conjunction with other network providers. Primary care hospitals have a written agreement with a full service hospital within the network for transfer, quality improvement, staff credentialling and training. Primary care hospitals provide a minimum set of core services including ambulatory care, inpatient medical care including non-sugical therapy and emergency medical services. Basic laboratory, radiology and related support must be available. Primary hospitals may also offer optional services such as chemotherapy, home care, hospice, full-service laboratories, rehabilitation, respite care, swing beds or dialysis. These facilities may also maintain continuous communication systems with a full service hospital(s).

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